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DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 156

[CMS-9943-IFC]

RIN 0938-AS28

Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums

AGENCY: Centers for Medicare and Medicaid Services, Department of Health and Human Services (HHS).

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule requires issuers of qualified health plans (QHPs), including stand-alone dental plans (SADPs), to accept premium and cost-sharing payments made on behalf of enrollees by the Ryan White HIV/AIDS Program, other Federal and State government programs that provide premium and cost sharing support for specific individuals, and Indian tribes, tribal organizations, and urban Indian organizations.

DATES: Effective Date: This interim final rule is effective on [OFR—Insert **date of public inspection** at OFR].

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [OFR—Insert date 60 days from the **date of public inspection** at the OFR].

ADDRESSES: In commenting, please refer to file code CMS–9943–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. You may submit comments in one of four ways (please choose only one of the ways listed).

1. Electronically. You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the “Submit a comment” instructions.
2. By regular mail. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9943–IFC, P.O. Box 8016, Baltimore, MD 21244–8016. Please allow sufficient time for mailed comments to be received before the close of the comment period.
3. By express or overnight mail. You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9943–IFC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.
4. By hand or courier. Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:
 - a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201. (Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)
 - b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850. If you intend to deliver your comments to the Baltimore address, call telephone

number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period. For information on viewing public comments, see the beginning of the SUPPLEMENTARY INFORMATION section.

FOR FURTHER INFORMATION CONTACT: Leigha Basini, (301) 492-4380 for questions related to this rule.

SUPPLEMENTARY INFORMATION: Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: <http://regulations.gov>. Follow the search instructions on that Web site to view public comments. Comments received timely also will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this final rule, we refer to the two statutes collectively as the “Affordable Care Act.”

As of October 1, 2013, for coverage that started as early as January 1, 2014, qualified individuals and qualified employers have been able to enroll in QHPs and SADPs – private health and dental insurance that has been certified as meeting certain standards – through competitive Marketplaces called “Exchanges” or “health insurance Marketplaces.” The word “Exchanges” refers to both State Exchanges, also called State-based Exchanges (SBEs), and Federally-facilitated Exchanges (FFE). In this final rule, when we refer to “FFEs,” we are also referring to State Partnership Exchanges. CMS has implemented Affordable Care Act provisions through regulations codified in title 45 of the Code of Federal Regulations (CFR), and, unless otherwise indicated, all regulatory references herein are to that title.

In the individual market Exchanges, premium and cost-sharing payment arrangements are generally managed directly between QHP and SADP issuers and enrollees. For those QHP enrollees eligible for advance payments of the premium tax credit and cost-sharing reductions, the federal government makes applicable payments to QHP issuers.

CMS has issued “Frequently Asked Questions” or “FAQs” with respect to premium and cost-sharing payments made by third parties on behalf of QHP enrollees. In a FAQ issued on November 4, 2013 (the November FAQ),¹ CMS encouraged QHP issuers not to accept third-party payments from hospitals, other healthcare providers, and other commercial entities due to concerns that such practices could skew the insurance risk pool and create an unlevel field in the Exchanges.

On February 7, 2014, CMS issued additional FAQs (the February FAQs) clarifying that the November FAQ was not intended to discourage QHP issuers from accepting third party premium and cost-sharing payments made by Indian tribes, tribal organizations, and urban Indian

¹ <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf>.

organizations, as well as by state and federal government programs (such as the Ryan White HIV/AIDS Program).² CMS affirmatively encouraged QHP issuers to accept such payments given that federal or state law or policy specifically envisions third party payment of premium and cost-sharing amounts by these entities.

Specifically, the Ryan White HIV/AIDS Program plays a critical role in ensuring that people living with HIV in the United States have access to life-saving antiretroviral medications, serving over 550,000 people living with HIV annually. Medication access is provided through both payment for medication and payment of insurance premiums and cost-sharing when such assistance is cost effective for the Ryan White HIV/AIDS Program. The Ryan White HIV/AIDS Program has been authorized to provide insurance assistance for low-income people living with HIV since 1990 under section 2615 of the Public Health Service Act, as added by the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (Pub. L. 101–381, title II, §201, Aug. 18, 1990). Section 2616(f) of the Public Health Service Act provides authority for states to use AIDS Drug Assistance Program grant funds to purchase or maintain health insurance or plans when the coverage includes the relevant therapeutics and the cost of such coverage does not exceed the costs of otherwise providing them directly. This provision was added in 2000 as subsection (e) by the Ryan White CARE Act Amendments of 2000 (Pub. L. 106-345, §204(b)) and was subsequently renumbered to (f) in 2006. Through Policy Notices 99-01, 7-05, and most recently 13-04, 13-05 and 13-06, the Health Resources and Services Administration HIV/AIDS Bureau has provided guidance to grantees reiterating that the funds awarded under the Parts A, B, and C of the Ryan White HIV/AIDS Program may be used to support a health insurance premium and costs-sharing assistance program as a core medical service for eligible low-income

² <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-payments-of-premiums-for-qualified-health-plans-in-the-marketplaces-2-7-14.pdf>.

people living with HIV when it is cost-effective for the program. Ryan White HIV/AIDS Program funds are payer-of-last-resort funds and may be used for public or private health insurance premiums, as well as cost-sharing (for example, deductibles, copayments, and coinsurance). In fiscal year 2013, the Ryan White HIV/AIDS Program AIDS Drug Assistance Program paid \$397,245,305 in premium assistance to issuers on behalf of program beneficiaries. As of June 2013, the Ryan White HIV/AIDS Program AIDS Drug Assistance Program provided premium assistance for 52,568 people living with HIV. These premium assistance expenditures were paid directly to issuers.

In addition, section 1312 of the Affordable Care Act, section 402 of the Indian Health Care Improvement Act, and 45 CFR 155.240(b) provides that Exchanges may permit Indian tribes, tribal organizations, and urban Indian organizations to pay aggregated QHP premiums on behalf of qualified individuals, subject to terms and conditions determined by the Exchange. In the past, a number of tribes have provided premium assistance to tribal members eligible to enroll in the Medicare Part D program. These arrangements have resulted in an increase in the number of tribal members enrolled in Medicare Part D. Building from that experience, these same arrangements are being replicated by tribes and tribal organizations in providing premium assistance to qualified individuals for QHPs in the Exchanges. Under these arrangements tribes aggregate premium payments to issuers and reduce their administrative costs.

II. Provisions of the Interim Final Rule

We have become aware that, despite related policy clarifications, some QHP issuers continue to reject payments of premium and cost sharing by the Ryan White HIV/AIDS Program. In particular, this QHP issuer practice is causing access problems for persons who rely on the Ryan White HIV/AIDS Program for assistance. Accordingly, we are promulgating a new

requirement at §156.1250 that QHP and SADPs must accept third party premium and cost sharing payments from the Ryan White HIV/AIDS Program.

To ensure that individuals reliant on programs similar to the Ryan White HIV/AIDS Program are not being adversely affected by QHPs' and SADPs' refusal to accept third party premium and cost-sharing payments, we are including within the new requirement that QHPs and SADPs must accept third party premium and cost-sharing payments from the following other entities in addition to the Ryan White HIV/AIDS Program: Indian tribes, tribal organizations, and urban Indian organizations; and state and federal government programs. This standard applies to all individual market QHPs and SADPs, regardless of whether they are offered through an FFE, an SBE, or outside of the Exchanges.

Our new standard does not prevent QHPs and SADPs from having contractual prohibitions on accepting payments of premium and cost sharing from third party payers other than those specified in this interim final regulation. In particular, as stated in our November FAQ, we remain concerned that third party payments of premium and cost sharing provided by hospitals, other healthcare providers, and other commercial entities could skew the insurance risk pool and create an unlevel competitive field in the insurance market. We continue to discourage such third party payments of premiums and cost sharing, and we encourage QHPs and SADPs to reject these payments.

We are also amending §156.805 to ensure that new §156.1250 can be enforced. Enforcement of FFE issuer standards and requirements is governed by §156.800 through §156.810. In the August 30, 2013 Program Integrity Rule (78 FR 54070, 54143), we established the bases for HHS to impose civil money penalties (CMPs) against QHP issuers for violations of certain standards applicable to issuers offering QHPs in the FFEs. In §156.805(a), we set forth

the grounds for imposing CMPs. Since the publication of that final rule, we noted that certain paragraphs under these sections should be clarified and, in some instances, technical corrections are necessary, to properly reflect when these enforcement remedies will apply. These clarifications and corrections are specifically necessary to reflect that these enforcement remedies will apply to violations of §156.1250. For example, under paragraph (1), the word “including” was inadvertently omitted from the phrase “misconduct in the Federally-facilitated Exchange or substantial non-compliance with the Exchange standards applicable to issuers offering QHPs in the Federally-facilitated Exchange [including] under subparts C through G of part 153 of this subchapter.” This same phrase also inadvertently referenced specific subparts within part 153, including subparts C and D, which contain standards and requirements for States in relation to the reinsurance and risk adjustment programs. We are therefore amending paragraph (1) so that it correctly provides that §156.805 targets violations of issuer standards and requirements of part 153 that are applicable to issuers. We are also making changes to clarify that substantial non-compliance with any Exchange standard or requirement applicable to issuers in the FFE is grounds for imposing CMPs and that reference to specific subparts of part 153 was not intended to be limit the types of QHP standards and requirements for which enforcement under this section would be available. We are further amending paragraph (1) to add an explicit reference to part 156, to clarify that substantial non-compliance with the Exchange standards applicable to issuers offering QHPs in the FFEs under part 156, including new §156.1250, may be a basis for the imposition of CMPs under §156.805.

Accordingly, failure to comply with the requirement to accept third party payments in accordance with §156.1250 could constitute a violation of §156.805(a)(1) as “substantial non-compliance with [an] Exchange standard[.]” Depending upon the circumstances, a QHP or

SADP issuer's failure to comply with §156.1250 could also fall under §156.805(a)(4) as a "practice that would reasonably be expected to have the effect of denying or discouraging enrollment into a QHP offered by the issuer (except as permitted by this part) by qualified individuals whose medical condition or history indicates the potential for a future need for significant medical services or items." Under §156.805(c), an issuer offering a QHP or SADP through an FFE may be subject to a maximum penalty of \$100 per day, per each individual who is adversely affected by the QHP or SADP issuer's non-compliance.

Issuers offering QHPs or SADPs through an SBE or outside of the Exchanges would be subject to any penalties that the SBE or the state has established to address issuer non-compliance with general QHP and SADP standards and requirements under part 156, Subpart M, in addition to any other SBE-specific or state-specific enforcement.

Qualified individuals in states with an FFE or SPE who are affected by a QHP's or SADP's violation of this new requirement, either because they are unable to effectuate coverage because an issuer will not accept the third party premium payments which the individual needs to be able to make a complete payment of the premium within the open enrollment time frame, or because they lose coverage due to the issuer's refusal to accept the required third-party premium or cost-sharing payments from entities described in 45 CFR 156.1250, may be eligible for an FFE special enrollment period (SEP) in accordance with §155.420(d)(9) and a certificate of exemption under §155.605(g)(1)(iii). CMS will issue additional guidance in the near future clarifying the specific criteria for obtaining the SEP or hardship exemption. We also encourage all SBEs to grant an SEP and certificate of exemption under these circumstances.

We continue to consider making additional regulatory changes to QHP and SADP issuer responsibilities to ensure that QHPs and SADPs accept third party premium and cost-sharing payments from the Ryan White HIV/AIDS Program, other state and federal government programs that support premium and cost sharing, and Indian tribes, tribal organizations, and urban Indian organizations.

III. Waiver of Proposed Rulemaking and Waiver of Delay in Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule before publishing a final rule that responds to comments and sets forth final regulations that generally take effect at least thirty days later. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued. CMS for good cause, under 5 U.S.C. 553(b)(B), finds that the notice-and-comment requirements of the Administrative Procedure Act (APA) would be impracticable and contrary to the public interest given that a delay in coverage for people who rely on one of the third parties noted in the regulation to pay their premiums could result in worsening medical conditions. Further, there is risk that one or more issuers may discontinue the existing QHP coverage of HIV/AIDS patients who are dependent on the Ryan White HIV/AIDS Program for premium assistance in the near future. Based on these same concerns, we find for good cause, under 5 U.S.C. 553(b)(B), that the notice-and-comment requirements of the APA would be impracticable and contrary to the public interest with respect to the clarification and correction of our enforcement authority at §156.805(a). For the reasons outlined above, the public interest requires that new §156.1250 be immediately enforced.

Additionally, section 553(d) of the APA (5 U.S.C. 553(d)) ordinarily requires that a final rule be effective not less than 30 days from the date of their publication in the **Federal Register**. This 30-day delay in effective date can be waived, however, if otherwise provided by an agency for good cause found and published with the rule. For the reasons set forth below, we also find good cause to waive the 30-day delay in effective date as unnecessary, impracticable and contrary to the public interest.

In this case, given the short timeframe under which this change must be implemented, delaying the promulgation and effectiveness of this rule would mean that some people who are eligible to enroll in a QHP but rely on the Ryan White HIV/AIDS Program, tribes and tribal organizations, or other state or federal programs to contribute to the cost of the premium, either in whole or in part, would not be able to effectuate their coverage. It could also mean that the third parties noted in the regulation would not be able to assist people who are already enrolled but do not have the funds to continue to pay their premiums, which could lead to coverage terminations for failure to pay premiums. Both of these scenarios could result in people's medical conditions worsening and an increase in uncompensated care. We consider this policy to be a benefit to consumers. Recent studies have demonstrated that individuals with HIV on antiretroviral medications who achieve viral load suppression are less likely to transmit HIV to others.³ Ensuring access to care and treatment services support the achievement of viral suppression, and, therefore, has a significant public health impact on HIV incidence as well.

The full scope of this issue and the need for §156.1250 was not known until after open enrollment began on October 1, 2013. We assumed that issuers of QHPs and SADPs would

³ Myron S. Cohen, Marybeth McCauley, and Theresa R. Gamble, HIV treatment as prevention and HPTN 052, *Current Opinion in HIV and AIDS*, Volume 7(2), p. 99-105 (March 2012); William Miller, Kimberly Powers, M. Kumi Smith, Myron S Cohen, Community viral load as a measure for assessment of HIV treatment as prevention, *Lancet Infect Dis* 13:459-64 (2013).

continue to accept these payments as these issuers had done prior to the availability of coverage through the Exchanges, and thus the impact of such third party payments was built into their baselines.⁴ Indeed, we expect that the vast majority of issuers already have been accepting these payments with this understanding. Similarly, with respect to the clarification of and correction to our enforcement authority at §156.1280(a), waiver of the 30-day-delay in effective date is necessary to enable CMS to take immediate enforcement action as necessary against those issuers who continue to refuse to accept the referenced third party payments. As described above, these actions could interfere with the ability of at-risk individuals to effectuate or maintain coverage.

Given the unusual circumstances and for the reasons outlined above, CMS finds good cause under the APA, 5 U.S.C. 553(b)(B) and (d)(3), to waive notice-and-comment rulemaking and to waive the delay in effective date and proceed directly with the issuance of a final rule with an immediate effective date.

IV. Collection of Information Requirements

This rule does not impose new or alter existing information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

V. Regulatory Impact Analysis

We have examined the impact of this final rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993) and Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act

⁴ For this reason, we do not believe that the new requirement in §156.1250 will have a material effect on the risk pools of QHP and SADP issuers. Further, starting in 2014, the risk adjustment, transitional reinsurance, and risk corridor programs offer new protection to issuers in the individual market against adverse selection.

(RFA) (September 19, 1980, Pub. L. 96-354), section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). It is CMS's belief that this final rule does not reach this economic threshold and thus is not considered a major rule.

This rule requires individual market QHPs and SADPs to accept premium payments made by certain third parties. The rule would also require individual market QHPs and SADPs to accept cost-sharing payments made by these third parties. We do not believe these actions would impose any significant new costs on issuers because we assume that the vast majority of issuers already accept such payments.

A. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the rule on small entities, unless the head of the agency can certify that the rule would not have a significant economic impact on a substantial number of small entities. Agencies must analyze options for regulatory relief for small businesses if a rule has a significant impact on a substantial number of small entities. The RFA generally defines a "small entity" as--(1) a proprietary firm meeting the size standards of the Small Business Administration (SBA); (2) a not-for-profit organization that is not dominant

in its field; or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of “small entity.” CMS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 percent. For the purposes of the regulatory flexibility analysis, we expect issuers offering individual market QHPs and SADPs operating in an FFE, an SBE or outside of the exchange to be affected by this proposed rule.

As discussed in Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act; Interim Final Rule,⁵ few, if any, issuers are small enough to fall below the size thresholds for small business established by the SBA. In that rule, we used a data set created from 2009 NAIC Health and Life Blank annual financial statement data to develop an updated estimate of the number of small entities that offer comprehensive major medical coverage in the individual and group markets. For purposes of that analysis, CMS used total Accident and Health earned premiums as a proxy for annual receipts. We estimated that there are 28 small entities with less than \$7 million in accident and health earned premiums offering individual or group comprehensive major medical coverage.⁶ However, this estimate may overstate the actual number of small health insurance issuers offering such coverage, since it does not include receipts from these companies’ other lines of business.

⁵ Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act; Interim Final Rule, 75 Federal Register 74864, 74918-20 (December 1, 2010) (codified at 45 C.F.R. Part 158).

⁶ According to SBA size standards, entities with average annual receipts of \$7 million or less would be considered small entities for North American Industry Classification System (NAICS) Code 524114 (Direct Health and Medical Insurance Carriers). For more information, see “Table of Size Standards Matched to North American Industry Classification System Codes,” effective March 26, 2012, U.S. Small Business Administration, available at <http://www.sba.gov>.

Therefore, we are not preparing an analysis for the RFA because we have determined, and the Secretary certifies, that this final rule will not have a significant economic impact on a substantial number of small entities.

B. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a proposed rule (and subsequent final rule) that includes any federal mandate that may result in expenditures in any one year by a state, local, or tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2014, that threshold is approximately \$141 million. UMRA does not address the total cost of a rule. Rather, it focuses on certain categories of costs, mainly those “federal mandate” costs resulting from: (1) imposing enforceable duties on State, local, or tribal governments, or on the private sector; or (2) increasing the stringency of conditions in, or decreasing the funding of, state, local, or tribal governments under entitlement programs.

This final rule requires QHPs and SADPs to accept premiums paid by certain third parties. Many issuers currently have systems in place to accept premium payments as part of the normal course of business, including payments made by people other than the insured. For example, the Ryan White HIV/AIDS Program AIDS Drug Assistance Program provided \$397,245,000 in premium assistance to issuers on behalf of Ryan White HIV/AIDS Program participants during fiscal year 2013. In June 2013, the Ryan White HIV/AIDS Program AIDS Drug Assistance Program provided premium assistance for 52,568 people living with HIV. These premium assistance expenditures were paid directly to issuers. Accordingly, this rule generally should not impose any significant new administrative costs on issuers. CMS has

concluded that this rule does not place any mandates on state, local, or tribal governments or the private sector that exceed the threshold for 2014.

C. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct costs on state and local governments, preempts state law, or otherwise has federalism implications. This rule does not impose any costs on state or local governments not otherwise imposed by already-finalized provisions of the regulations implementing the Affordable Care Act.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy-making discretion of the states, CMS has engaged in efforts to consult with and work cooperatively with affected states, including participating in conference calls with and attending conferences of the NAIC, and consulting with State insurance officials on an individual basis. We believe that this rule does not impose substantial direct costs on state and local governments, preempt state law, or otherwise have federalism implications. We are amending the operational requirements for QHPs and SADPs. Under the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this regulation, the Department of Health and Human Services certifies that CMS has complied with the requirements of Executive Order 13132 for the attached proposed regulation in a meaningful and timely manner.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

D. Congressional Review Act

The Congressional Review Act, 5 U.S.C. 801, et seq., as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. We will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**

List of Subjects in 45 CFR Part 156

Administrative appeals, Administrative practice and procedure, Administration and calculation of advance payments of premium tax credit, Advertising, Advisory Committees, Brokers, Conflict of interest, Consumer protection, Cost-sharing reductions, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, American Indian/Alaska Natives, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Payment and collections reports, Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, and Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR part 156 as set forth below:

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

1. The authority citation for part 156 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301–1304, 1311–1313, 1321–1322, 1324, 1334, 1342–1343, 1401–1402, Pub. L. 111-148, 124 Stat. 119 42 U.S.C. 18021-18024, 18031-18032, 18041-18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).

2. Section 156.805 is amended by revising paragraph (a)(1) to read as follows:

§156.805 Bases and process for imposing civil money penalties in Federally-facilitated Exchanges.

(a) * * *

(1) Misconduct in the Federally-facilitated Exchange or substantial non-compliance with the Exchange standards and requirements applicable to issuers offering QHPs in the Federally-facilitated Exchange, including but not limited to issuer standards and requirements under parts 153 and 156 of this subchapter;

* * * * *

3. Section 156.1250 is added to read as follows:

§156.1250 Acceptance of certain third party payments.

Issuers offering individual market QHPs, including stand-alone dental plans, must accept premium and cost-sharing payments from the following third-party entities on behalf of plan enrollees:

- (a) Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
- (b) Indian tribes, tribal organizations or urban Indian organizations; and
- (c) State and Federal Government programs.

Dated: March 11, 2014

Marilyn Tavenner,
Administrator,
Centers for Medicare & Medicaid Services.

Approved: March 12, 2014

Kathleen Sebelius,
Secretary,
Department of Health and Human Services.

BILLING CODE 4120-01-P

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